Hoosier Healthwise Glossary

Item No.	Key Term	Acronym	Definition	Source
1	Abandonment Rate		The rate of telephone calls received during business hours that are abandoned before being answered by a live voice.	HEDIS 2004 Technical Specifications
2	Access		The member's ability to get needed medical care and services within a reasonable time or travel distance.	CMS Medicaid Managed Care Glossary (www.cms.hhs.gov/glossary)
3	Action		The denial or limited authorization of a requested service, including the type or level of service; reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; or failure of a managed care organization or prepaid insurance health plan to act within the required timeframes.	As Defined In 42 CFR 438.400(b)
4	Ancillary Services		Professional services by a hospital or other supplemental health services, such as x-ray, drug, rehabilitation, home health, durable medical equipment or laboratory.	Medical Insurance Glossary Of Terms
5	Appeal		A request for review of an action, including the following: (1) The denial or limited authorization of a requested service (2) The reduction, suspension or termination of a previously authorized service (3) The denial, in whole or in part, of a payment for a service (4) The failure to provide services in a timely manner (5) The failure of a managed care organization (MCO) or pre-paid insurance health plan (PIHP) to act within the timeframes provided (6) For a resident or a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right to obtain services outside the network	As Defined In 42 CFR 438.400(b)
6	Automated Voice Response	AVR	A system that helps providers obtain pertinent information Hoosier Healthwise member eligibility, benefit limitation, Hoosier Healthwise managed care membership, including delivery system and Primary Medical Provider (PMP) information. Enrollee information obtained through the automated voice response system is confidential.	Indiana Health Coverage of Programs Provider Manual

Item No.	Key Term	Acronym	Definition	Source
7	Average Length of Stay	ALOS	The average length of time in calendar days that all Hoosier Healthwise members in a plan incur in an acute care hospital during a reporting period minus the discharge day.	Hoosier Healthwise MCO Reporting Manual
8	Balance Billing		A situation in which providers bill the consumer for any charges not reimbursed in full by the insurance carrier. Medicaid does not allow providers to balance bill Medicaid consumers.	Medical Insurance Glossary Of Terms
9	Balanced Budget Act of 1997		Federal Public Law 105-33 that makes numerous changes to various titles of the Social Security Act and creates a new Title XXI, the State Children's Health Insurance Program (SCHIP).	MCO Policies and Procedure Manual
10	Benefit Advocate		A staff member or subcontractor of the enrollment broker who must perform outreach, education, enrollment facilitation, and Primary Medical Provider (PMP) choice counseling for members and potential enrollees.	RFP-4-79, Attachment F, Section 4.2
11	Capitation Rate		A set of fixed fees that the Office of Medicaid Policy and Planning (OMPP) pays monthly to eligible managed care organizations (MCOs) for each enrolled Hoosier Healthwise member. These fees are for the provision of covered medical and health services whether the enrollee received services during the month for which the fee is intended. These rates vary by eligibility category.	MCO Policies and Procedure Manual
12	Care Coordination		An active, ongoing process by which the plan assists the member in identifying, accessing and using community resources and coordinating the services to meet individual health care needs.	Indiana Health Coverage Program Manual

Item No.	Key Term	Acronym	Definition	Source
13	Carved-out Services		Services that are excluded from the plan's capitated payment amount but are still a covered benefit for enrollees. These services include: (1) Services provided by a school as part of a student's Individualized Education Plan (IEP) (2) Dental services rendered by providers enrolled in the Indiana Health Coverage Program (IHCP) in a dental specialty (3) Behavioral health services, including mental health and substance abuse and chemical dependency services, rendered by the IHCP mental health providers in an outpatient setting	RFP-4-79 Attachment D, Section 2.2
14	Case Management		A process employing a doctor, nurse, or other health professional (i.e., case managers) to manage a patient's health care. Case managers ensure patients receive needed services, and track patients' use of facilities and resources.	Medical Insurance Glossary Of Terms
15	Centers for Medicare and Medicaid Services	CMS	The Federal agency responsible for overseeing and providing funds for Medicare, state Medicaid and Children's Health Insurance Plan (CHIP) programs such as Medicaid, Medicaid Select and the Hoosier Healthwise program.	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
16	Central Region		The State is divided into geographic regions for the purpose of capitation rate calculation. The Central Region includes the following counties: Benton, Blackford, Boone, Carroll, Clinton, Delaware, Fayette, Fountain, Grant, Hamilton, Hancock, Hendricks, Henry, Howard, Jay, Johnson, Madison, Marion, Montgomery, Morgan, Parke, Putnam, Randolph, Rush, Shelby, Tippecanoe, Tipton, Union, Vermillion, Warren and Wayne.	MCO Policies and Procedure Manual

Item No.	Key Term	Acronym	Definition	Source
17	Children's Health Insurance Program	CHIP	As part of the Balanced Budget Act of 1997, Congress created the State Children's Health Insurance Program (SCHIP) as a way to encourage states to provide health insurance to uninsured children. The Federal law gives states the option to develop a children's health insurance program that is: (1) A Medicaid expansion (2) A separate state-run health insurance program (3) A combination of a Medicaid expansion and a state program. The Indiana program is a combination program and included in Hoosier Healthwise.	MCO Policies and Procedure Manual
18	Claim Dispute Resolution Process		A process that provides a channel for providers to address an unresolved informal claims decision.	Hoosier Healthwise MCO Reporting Manual
19	Clean Claim		Claim comprised of the essential data elements which may be described in the payer's contract or provider's manual; additional clean claim elements which may be specified by the payer; and coordination or non-duplication of benefits.	As Defined In IC 12-15-13-0.5 and IC 12-15-13-0.6
20	Clinical Advisory Committee	CAC	The committee established by the Office of Medicaid Policy and Planning (OMPP) comprised of actively participating medical providers enrolled in the Indiana Health Coverage Program (IHCP). The Clinical Advisory Commission's purpose is to provide clinical insights in the application of managed care policies to ensure high quality, cost effective and appropriate delivery of services to Indiana's managed care members.	As Defined In IC 12-15-33

Item No.	Key Term	Acronym	Definition	Source
21	Clinical Performance Measure		A method to determine, estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medical review criteria or standards of quality health care delivery.	Medical Insurance Glossary Of Terms
22	Clinical Practice Guidelines		Process reports written by medical experts outlining accepted methods for treatment of individuals with specific symptoms, diagnosed illness, or disease entities. These guidelines are used to determine appropriate treatment and, in managed care, to approve the reimbursement for the treatment.	Medical Insurance Glossary Of Terms
23	Cold-call Marketing		Any unsolicited personal contact with a potential enrollee by an employee or agent of a managed care organization for the purpose of influencing the individual to enroll or disenroll with the managed care organization.	As Defined In 42 CFR 438.104(a)
24	Confirmation Report		The monitoring contractor's form letter, sent each quarter to the plans, which verifies the data for the Indiana Hoosier Healthwise program was received.	Hoosier Healthwise MCO Reporting Manual
25	Consumer Assessment of Health Plans Study	CAHPS	A member satisfaction survey which is a component of the managed care accreditation process sponsored by the National Committee for Quality Assurance (NCQA). Member survey form adopted by the Office of Medicaid Policy and Planning (OMPP) for 2004 Health Plan Employer Data and Information Set (HEDIS) and future member surveys.	Medical Insurance Glossary Of Terms
26	Coordination of Benefits		A procedure for determining which insurance plan will be primarily responsible for payment of the rendered health care services.	Medical Insurance Glossary Of Terms
27	Co-payments		The portion of a medical expense that a member must pay. Certain services such as transportation, non-emergency use of the emergency room, and pharmacy may be subject to a member co-payment under the Medicaid program.	MCO Policies and Procedures Manual

Item No.	Key Term	Acronym	Definition	Source
28	Cost Avoidance		A situation in which a Medicaid payment is denied or reduced because coverage is available from a liable third party.	RFP-4-79, Attachment D, Section 6.6
29	Covered Service		A service for which payment is available under the Indiana Health Coverage Program (IHCP) subject to the limitations of the *Indiana Administrative Code* (IAC).	Indiana Health Coverage Program Manual
30	Credentialing		The process by which a plan reviews and evaluates qualifications of licensed independent practitioners to provide services to its members. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, as well as for conformity to the plan's utilization and quality management requirements.	National Committee for Quality Assurance 2003 Managed Care Organizations Standards and Guidelines
31	Current Procedural Terminology	CPT	Codes for medical or psychiatric procedures performed by physicians and other health providers. The codes were developed by the Centers for Medicare and Medicaid Services (CMS) to assist in the assignment of reimbursement amounts to providers by Medicare carriers.	careworks.com/dictionary/dict_c/htm
32	Delivery System		There are two delivery systems of health care in Hoosier Healthwise: (1) Prime*Step* /Primary Care Case Management (PCCM) (2) Managed Care Organizations/Risk Based Managed Care (RBMC)	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
33	Diagnosis-Related Group	DRG	A classification system that identifies patients according to diagnosis, type of treatment, age and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single diagnosis related group (DRG) category, regardless of the actual cost of care.	Medical Insurance Glossary Of Terms

Item No.	Key Term	Acronym	Definition	Source
34	Disease Management		An approach to patient care that emphasizes coordinated comprehensive care along the continuum of disease and across health care services. It includes coordination of educational, promotional, preventive, diagnostic and therapeutic services and decisions.	RFP-4-79, Attachment D, Section 2.8
35	Disenrollment		Disenrollment can be one of the following: (1) Disenrollment due to Indiana Health Coverage Programs (IHCP) eligibility – the member is no longer eligible to receive Indiana Health Coverage Programs services (2) Disenrollment due to program eligibility – the member is eligible to receive IHCP services but not eligible to be in managed care due to transition into one of the population exclusion criteria (e.g., member now in a waiver program) (3) Disenrollment from a managed care organization (MCO)–the member has changed his/her Primary Medical Provider (PMP) and the new PMP is in another health plan	RFP-4-79, Attachment F, Section 4.3
36	Division of Family Resources /Department of Child Services	DFR/DCS	This division/department administers programs for families and children focusing on prevention, early intervention, self-sufficiency and preservation. Programs include Temporary Assistance to Needy Families (TANF) (DFR), food stamps (DFR), housing (DFR), child support (DCS), child protection (DCS), childcare (DFR) adoption (DCS), homeless services (DFR) and job programs (DFR). This division supports the Office of Medicaid Policy and Planning (OMPP) by determining Medicaid/Children's Health Insurance Plan (CHIP) eligibility. At least one local Office of Family Resources/Child Services is located in each Indiana county.	RFP-4-79 Attachment F, Section 1.3

Item No.	Key Term	Acronym	Definition	Source
37	Drug Utilization Review Board	DUR	The Indiana Drug Utilization Review Board is appointed by the governor to serve in an advisory capacity to Indiana Medicaid with regard to the prescription and dispensing of drugs by Medicaid providers and the use of drugs by Medicaid recipients. The board, composed of representatives of the pharmacy, medical, and scientific community has a responsibility to establish criteria for both retrospective review and prospective surveillance of drug prescription and dispensing for and use by Medicaid recipients.	As Defined In IC 12-15-35
38	Dual Eligibles		Those who are enrolled and eligible for both Medicaid and Medicare services (i.e., Medicare/Medicaid beneficiaries).	Center for Medicare and Medicaid Services General Glossary http://www.cms.hhs.gov/glossary/
39	Durable Medical Equipment	DME	Items of medical equipment owned or rented and placed in the home to facilitate treatment and/or rehabilitation, generally consisting of items that can withstand repeated use; primarily and customarily used to serve a medical purpose and is usually not useful to a person in the absence of illness or injury.	www.pohly.com/terms_d_html
40	Early Periodic Screening, Diagnosis and Treatment	EPSDT	Those services described at 405 IAC 5-15 as required by Federal law pursuant to 42 U.S.C. 1396d(r), which include certain preventive services to children under 21 years of age.	MCO Policies and Procedures Manual
41	Electronic Data Services	EDS	The fiscal agent for Indiana Health Coverage Programs IHCP), including Hoosier Healthwise, responsible for matters related to the development, maintenance and operation of Indiana*AIM*. Major responsibilities include claim adjudication, provider enrollment and payment to providers.	MCO Policies and Procedures Manual

Item No.	Key Term	Acronym	Definition	Source
42	Eligibility Verification System	EVS	There are three eligibility verification systems available to providers: (1) Automated Voice Response (AVR) System (2) Electronic Verification (3) OMNI Response	Indiana Health Coverage Program Manual
43	Emergency Medical Condition		A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy (2) Serious impairment to bodily functions (3) Serious dysfunction of any bodily organ or part.	As Defined In The Medicaid Managed Care Final Rules, 42 CFR 438.114 and In IC 12-15-12
44	Encounter Data		Individual patient encounters with a managed care organization's health care network. Encounter data contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts and rendering providers' identification numbers and other detailed claims data required for quality improvement monitoring and utilization analysis. Encounter data is also referred to as "shadow claims".	RFP-4-79, Attachment D, Section 6.5
45	Enrollee		A Medicaid recipient who is currently enrolled in a managed care organization (MCO) or a primary care case management (PCCM) program in a given managed care program, such as Hoosier Healthwise.	As Defined In 42 CFR 438.10
46	Enrollment Broker		The contractor that is responsible for educating potential Hoosier Healthwise enrollees and enrolling them in Hoosier Healthwise. This contractor is also responsible for maintaining the Hoosier Healthwise Helpline.	As Defined In 42 CFR 438.810(a)

Item No.	Key Term	Acronym	Definition	Source
47	Enrollment Center		A health care service provider or community agency authorized by the Indiana Family and Social Services (IFSSA) Division of Family Resources (DFR) to facilitate applications for Hoosier Healthwise.	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
48	Expedited Appeal Review		A review of an issue that would seriously jeopardize the life or health of a member or the member's ability to regain maximum function.	Hoosier Healthwise MCO Reporting Manual
49	Expedited Grievance		A grievance regarding an issue that would seriously jeopardize the life or health of a member or the member's ability to reach and maintain maximum function.	Hoosier Healthwise MCO Reporting Manual
50	Federal Poverty Level	FPL	Family income guidelines set by the federal government for the administration of social service benefits. The state-specific guidelines are adjusted for the cost of living in each state. Financial eligibility for social service programs is often based on a percentage of the FPL.	RFP-4-79, Attachment E, Section 1.0
51	Federally Qualified Health Center	FQHC	A publicly funded health care network established under the Omnibus Budget Reconciliation Act (OBRA) of 1989 to increase access to medical care for the homeless, the underinsured and the uninsured	MCO Policies and Procedures Manual Glossary
52	Feedback Report		Standard form letter for each managed care organization, completed by the monitoring contractor, that summarizes the performance plan data reported that quarter. The letter identifies irregular results that require plan explanations of the data trends.	Hoosier Healthwise MCO Reporting Manual
53	Fiscal Agent Contractor		The contractor that is responsible for Indiana*AIM*, the Indiana Health Coverage Programs' (IHCP) Medicaid Managed Information System (MMIS), and for managing all of the information systems related to the processing and reporting of member and provider enrollment, and claims data for the IHCP.	RFP-4-79, Attachment F, Section 3.2

Item No.	Key Term	Acronym	Definition	Source
54	Fiscal Year		The designated annual reporting period for an entity. Indiana State fiscal year (SFY) is July 1 through June 30. The Federal fiscal year (FFY) is October 1 through September 30.	Indiana Health Coverage of Programs Provider Manual
55	Full-time Equivalent	FTE	The equivalent of one full-time employee.	Kongstvedt, Peter R. 2001. Essentials of Managed Health Care, 4th Edition. Gaithersburg, Maryland: Aspen Publishers.
56	Grievance		An expression of dissatisfaction about any matter other than an action. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process.	As Defined In 42 CFR 438.400(b)
57	Health Care Financing Administration	HCFA	The former name of the Centers for Medicare and Medicaid Services (CMS), a division of the United States Department of Health and Human Services.	MCO Policies and Procedures Manual Glossary
58	Health Insurance Portability and Accountability Act of 1996	HIPAA	A Federal legislation that allows persons to qualify immediately for comparable health insurance coverage when changing employment relationships. Title II, Subtitle F, gives the Department of Health and Human Services the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. [More information about the Health Insurance Portability and Accountability Act of 1996 is available at: http://www.hipaa.com/]	Medical Insurance Glossary Of Terms

Item No.	Key Term	Acronym	Definition	Source
59	Health Maintenance Organization	HMO	An entity that operates a prepaid health care delivery plan that is licensed by the Indiana Department of Insurance as a health maintenance organization. A health maintenance organization is also referred to as a managed care organization (MCO).	Kongstvedt, Peter R. 2001. Essentials of Managed Health Care, 4th Edition. Gaithersburg, Maryland: Aspen Publishers.
60	Health Plan Employer Data and Information Set	HEDIS	Developed by the National Committee for Quality Assurance (NCQA), it is the most widely used set of performance measures in the industry.	HEDIS 2004 Technical Specifications
61	Helpline		A 24-hours a day, seven-days a week telephone line, available for Hoosier Healthwise members to call with any questions or problems with the program. Helpline staff may refer the question or problem to another entity if appropriate for resolution.	MCO Policies and Procedures Manual
62	Home- and Community-based Services Waiver Program	HCBS	Provides home and community based services (HCBS) not otherwise reimbursed by the Indiana Health Coverage Program (IHCP). Participants would require institutionalization in the absence of the waiver services. Individuals may not be enrolled in Hoosier Healthwise and be enrolled in a HCBS waiver at the same time.	MCO Policies and Procedure Manual
63	Hoosier Healthwise		Hoosier Healthwise is the name for Indiana's Medicaid and Children's Health Insurance Plan (CHIP) sponsored managed health care program for eligible children, pregnant women and low-income families. The two delivery systems in the Hoosier Healthwise program are: (1) Primary Care Case Management (PCCM) (2) Risk-based Managed Care (RBMC)	RFP-4-79, Attachment E, Section 1.0
64	Hoosier Healthwise Health Plan		A health insurance plan that includes health maintenance organizations (HMOs) or managed care organizations (MCOs) contracting with the State in the Risk-based Managed Care (RBMC) delivery system or the Primary Care Case Management (PCCM) delivery system, also known as Prime*Step* . The plan delivers covered health care services to enrolled members.	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff

Item No.	Key Term	Acronym	Definition	Source
65	Indiana Family and Social Services Administration	IFSSA	The Indiana Family and Social Services Administration (IFSSA) provides services for low-income individuals and families, children, senior citizens, people with mental illness, people with addictions and people with physical and developmental disabilities.	RFP-4-79, Attachment F, Section 1.0
66	Indiana Health Coverage Programs	IHCP	Includes health care programs (i.e., 590 Program, Traditional Medicaid, Hoosier Healthwise, HoosierRx and *Medicaid Select*). *Medicaid Select* is a Primary Care case Management (PCCM) program for aged, blind, and disabled. Hoosier Healthwise includes Medicaid and Children's Health Insurance Plan (CHIP) children, pregnant women, and low income families.	Indiana Health Coverage Program Manual
67	Indiana Health Coverage Programs Hospice Provider		A public or private organization (or subdivision of either) that is engaged in providing care to terminally ill individuals and their families, is certified under Medicare conditions of participation, and has a valid Indiana Health Coverage Program (IHCP) provider agreement indicating an intent to provide hospice services.	Indiana Health Coverage Programs Hospice Provider Manual
68	Indiana State Department of Health	ISDH	The State agency responsible for promotion of health; providing guidance on public health issues; ensuring the quality of health facilities and programs and the administration of certain health programs. The Bureau of Family Health Services is the bureau within the Indiana State Department of Health (ISDH) organization charged with the administration of the Children's Special Health Care Services Division (CSHCS) as well as the Maternal and Child Health Division (MCH) and the Division of Women, Infants, and Children (WIC).	Indiana Health Coverage of Programs Provider Manual

Item No.	Key Term	Acronym	Definition	Source
69	Indiana State Department of Insurance	IDOI	The Department of Insurance enforces statutes and regulations applicable to the operation of insurance companies including health maintenance organizations (HMOs) and preferred provider organizations (PPOs), the issuance of insurance policies, the handling of complaints, and the dissemination of public insurance information.	Indiana Department of Insurance Website: www.in.gov/idoi
70	Indiana*AIM*		The Indiana Advanced Information Management System (i.e., Indiana*AIM*) is the name for the State's Medicaid Management Information System (MMIS).	MCO Policies and Procedure Manual
71	In-network Provider		A provider included in a member's health plan's network for a member or under contract to a managed care organization (MCO) to render services to its members.	Hoosier Healthwise MCO Reporting Manual
72	Liquidated Damages		An amount of financial remuneration that a plan must pay to the State in the event that the plan fails to meet performance requirements or reporting standards set forth in the State's contract, procurement document, or reporting requirements schedule.	RFP-4-79, Attachment D, Section 8.0
73	Lock-In		Restriction of a member to particular providers, as determined by the State for the purpose of reducing fraud and abuse by the member. A lock-in member is required to obtain an Indiana Health Coverage Program (IHCP) covered services from specifically-designated providers only. Lock-in is also known as the "Restricted Card Program".	Indiana Health Coverage of Programs Provider Manual
74	Managed Care Organization	MCO	A contracting organization that assumes financial risk for arranging or administering a health care delivery system for Hoosier Healthwise enrollees and paying for covered health care services. Managed care organizations (MCOs) can also be known as health maintenance organizations (HMOs).	Kongstvedt, Peter R. 2001. Essentials of Managed Health Care, 4th Edition. Gaithersburg, Maryland: Aspen Publishers.

Item No.	Key Term	Acronym	Definition	Source
75	Mandatory MCO Enrollment		Hoosier Healthwise members who reside in selected counties must be enrolled in a managed care organization (MCO) plan. This does not affect the *Medicaid Select* or Traditional Medicaid fee-for-service (FFS) members. Mandatory managed care programs are also known as the mandatory risk-based managed care (mandatory RBMC) program.	RFP-4-79, Attachment E, Section 3.2
76	Marketing		Communication from a plan to a potential or enrolled Hoosier Healthwise member who is not enrolled in that entity, that can reasonably be interpreted as intended to influence enrollment in that particular plan, or either to not enroll in, or to disenroll from, another plan.	As Defined In 42 CFR 438.104
77	Marketing Materials		Materials that are produced in any medium, by or on behalf of a plan that can reasonably be interpreted as intended to market to potential enrollees**.**	RFP-4-79, Attachment D, Section 3.2
78	Medicaid Management Information System	MMIS	The medical assistance and payment information system for the Indiana Health Coverage Program (IHCP) known as Indiana*AIM* .	MCO Policies and Procedure Manual
79	Medicaid or Medical Assistance Program		Medicaid is a federal-state funded medical assistance program administered by the State to provide reasonable and necessary medical care for persons meeting both medical and financial eligibility requirements pursuant to federal and state law.	As Defined In 42 U.S.C. 1396 and Indiana State Law, IC 12-15
80	*Medicaid Select*		A managed care program started in January 2003 for non-institutionalized Medicaid enrollees in certain aid categories including the aged, blind, disabled, dual eligibles (Medicare and Medicaid), adoption assistance, room and board assistance and Medicaid For Employees with Disabilities (M.E.D.) Works participants.	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
81	Medicaid/Children's Health Insurance Plan Covered Service	Medicaid/ CHIP	A service provided or authorized by a IHCP provider for an enrollee for which payment is available under the Indiana Medicaid program as set forth in 405 IAC 5. A list of covered services is referenced in IC 12-15-5-1 for Medicaid.	MCO Policies and Procedure Manual

Item No.	Key Term	Acronym	Definition	Source
82	Medically Reasonable and Necessary Service		Service that meets current professional standards commonly held to be applicable to the case.	As Defined In 405 IAC 5-2-17
83	Member Identification Number		The member identification number may also be called recipient identification (RID) number. This number is on the enrollee's Hoosier Healthwise card.	MCO Policies and Procedure Manual
84	Memorandum of Collaboration	MOC	A written agreement specific to the Hoosier Healthwise program which provides a formal description of the terms of collaboration between a Primary Medical Provider (PMP) and a preventive health care service provider (PHCSP). This agreement specifies the referred services and the responsibilities of each participant and must be signed by both parties, and approved by the Office of Medicaid Policy and Planning (OMPP).	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
85	Monitoring Contractor		The business entity under contract with the State to assist the State in monitoring the performance of the managed care entities participating in the Hoosier Healthwise program. Duties include: (1) Performing a readiness review of newly contracted managed care organizations (2) Reviewing and analyzing data submitted in managed care organization quarterly reports and maintaining the MCO Reporting Manual (3) Facilitating the Clinical Studies and Quality Improvement Committee Meetings (4) Conducting shadow claims validation activities (5) Participating in the monthly Managed Care Policy meetings (6) Compiling Health Plan Employer Data and Information Set (HEDIS) data and providing technical assistance support in the production of HEDIS data and producing the HEDIS report	RFP-4-79, Attachment F, Section 3.4

Item No.	Key Term	Acronym	Definition	Source
86	National Committee for Quality Assurance	NCQA	A non-profit organization that accredits and measures the quality of care in managed care plans, health maintenance organizations (HMOs) and Medicare health plans. The National Committee for Quality Assurance (NCQA) also maintains the Health Plan Employer Data and Information Set (HEDIS).	Medical Insurance Glossary Of Terms
87	Network		A group of doctors, hospitals, pharmacies, and other health care experts that provide health care services to a managed care organization's membership for a pre-determined and set reimbursement rate. A group of contracted primary, specialist and ancillary providers organized for the purposed of rendering services to a group of enrolled members.	Medical Insurance Glossary Of Terms Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
88	Northern Region		The State is divided into geographic regions for the purpose of capitation rate calculation. The Northern Region includes the following counties: Adams, Allen, Cass, Dekalb, Elkhart, Fulton, Huntington, Jasper, Koscioko, Lgrange, Lake, LaPorte, Marshall, Miami, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Wabash, Wells, White, and Whitley.	MCO Policies and Procedure Manual
89	Office of Children's Health Insurance Program	CHIP	The office within the Indiana Families and Social Services Administration (IFSSA) that administers the Children's Health Insurance Program (CHIP).	MCO Policies and Procedure Manual
90	Office of Medicaid Policy and Planning	OMPP	The office within the Indiana Family and Social Services Administration (IFSSA) that is the designated single state agency that administers the Indiana Health Coverage Programs (IHCP). The Office of Medicaid Policy and Planning (OMPP) is responsible for developing the policies and procedures for Hoosier Healthwise.	RFP-4-79, Attachment F, Section 2.0
91	OMNI Machine		Sometimes referred to as the "swipe" machine, this is the point of service eligibility verification system, used by swiping the enrollee's plastic Hoosier Healthwise card through the OMNI 380 terminal device.	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff

Item No.	Key Term	Acronym	Definition	Source
92	Open Panels		Available slots for new members to enroll with a primary medical provider, who is not full to member capacity and is able to accept new patients.	MCO Policies and Procedure Manual
93	Out-of-network Provider		A provider not included in a member's health plan's network for a member or not under contract to a managed care organization (MCO) to render services to its members.	Hoosier Healthwise MCO Reporting Manual
94	Outpatient Hospital		Health care services that are rendered in an acute care hospital facility but do not require the individual to be admitted overnight for treatment. These services typically include diagnostic, therapeutic (both surgical and non-surgical), rehabilitation and ambulatory services.	Medical Insurance Glossary Of Terms
95	Package A		Full Medicaid coverage for low income families, with children under 18 years, including those receiving Temporary Assistance for Needy Families (TANF); children whose families do not receive TANF, but who are under age 21 and meet the eligibility requirements; pregnant women who meet the TANF income and resource criteria; wards of the state and foster children (on a voluntary basis); and CHIP Phase I, children under age 19 whose family's income is up to 150% of federal poverty level.	RFP-4-79, Attachment E, Section 6.0
96	Package B		Pregnancy-related coverage is provided to women whose income is below 150 percent of poverty without regard to their resources. Eligibility extends up to 60 days postpartum.	RFP-4-79, Attachment E, Section 6.0
97	Package C		Preventive, primary and acute care services for children under age 19 whose family's income is 150-200 percent of federal poverty level.	RFP-4-79, Attachment E, Section 6.0

Item No.	Key Term	Acronym	Definition	Source
98	Paid Claim		A "paid" claim is a billing encounter notice submitted for reimbursement consideration or utilization documentation that itemizes service(s) (i.e., claim line items) rendered to a covered person eligible to receive the service(s) on the date rendered in which at least one of the services (i.e., claim line item(s)) is partially or fully reimbursable or deemed eligible for full or partial reimbursement if the submitting entity had not been pre-paid for the (healthcare) service(s).	Hoosier Healthwise MCO Reporting Manual
99	Panel Size		The number of Hoosier Healthwise member assignments that a Primary Medical Provider (PMP) is willing to accept to service. The minimum panel size is 150 members and the maximum is 2,000 members. The panel size designation is included in the PMP's Hoosier Healthwise contract.	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
100	Performance Measures		A gauge used to assess the performance of a process or function of any organization. Quantitative or qualitative measures of care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual's or organization's performance, such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services.	Medical Insurance Glossary Of Terms
101	Pharmacy Benefit Manager	PBM	Specialized business entities established to provide a broad spectrum of outsourced pharmacy benefit management services for their private and public payer-customers on a stand-along or carve-out basis.	Kongstvedt, Peter R. 2001. Essentials of Managed Health Care, 4th Edition. Gaithersburg, Maryland: Aspen Publishers.
102	Physician Incentive Plans	PIP	Reimbursement methods under which a physician's income from a plan is affected by the physician's performance or overall performance of the plan, such as utilization, medical cost, quality measurements and member satisfaction.	RFP-4-79, Attachment D, Section 4.11
103	Plan of Care		A formal plan developed to address the specific needs of an individual to link clients with needed services.	Indiana Health Coverage of Programs Provider Manual

Item No.	Key Term	Acronym	Definition	Source
104	Preventive Health Care Service Provider	PHCSP	An IHCP-enrolled primary care provider or advanced practice nurse who, as part of his/her normal scope of practice, renders primary and preventive care services.	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
105	Primary Care Case Management	PCCM	One of the delivery systems of Hoosier Healthwise, in which members are linked to a Primary Medical Provider (PMP) who contracts directly with the State of Indiana. The PMP is responsible for coordinating designated covered services and is reimbursed on a fee-for-service basis.	RFP-4-79, Attachment E, Section 3.1
106	Primary Medical Provider	PMP	Those contracted physicians who are responsible for providing primary and preventive care, and for authorizing other covered services as needed, and within the scope of their contracts to authorize, for members of Hoosier Healthwise.	RFP-4-79 Attachment D, Section 4.2
107	Prime*Step*		The name of the Hoosier Healthwise Primary Care Case Management (PCCM) health plan.	RFP-4-79, Attachment E, Section 3.1
108	Prior Authorization		The procedure for the office's prior review and authorization, modification for covered medical services and supplies. It is based on medical reasonableness, necessity, and other criteria.	Indiana Health Coverage of Programs Provider Manual
109	Prudent Layperson		A person who possesses an average knowledge of health and medicine. In an emergency care services setting, a prudent layperson can reasonably determine if the absence of medical attention to an individual would place the individual's health in serious jeopardy.	As Defined In The Medicaid Managed Care Rules, 42 CFR 438.114
110	Quality Improvement		The effort to assess and improve the level of performance of key processes and outcomes within an organization. Opportunities to improve care and service are usually found by examining the systems and processes that provide them.	National Committee for Quality Assurance 2003 MCO Standards and Guidelines

Item No.	Key Term	Acronym	Definition	Source
111	Quality Improvement Committee	QIC	The committee established by the Office of Medicaid Policy and Planning (OMPP) that serves to provide oversight for the appropriateness and quality of care provided to Hoosier Healthwise members by establishing standards and guidelines for the provision of care. The Quality Improvement Committee is responsible for integrating the quality improvement process and serves as a coordinating and advisory body.	MCO Policies and Procedure Manual
112	Readiness Review		A process to evaluate a plan's operational preparedness to provide services to Hoosier Healthwise members prior to enrolling Hoosier Healthwise managed care members.	RFP-4-79, Attachment D, Section 1.1
113	Recipient Identification Number	RID	The member identification number on the enrollee's Hoosier Healthwise card.	MCO Policies and Procedure Manual
114	Re-credentialing		The process by which a plan re-evaluates qualifications of licensed independent practitioners to provider services to its members. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, as well as for conformity to the plan's utilization and quality management requirements.	National Committee for Quality Assurance 2003 MCO Standards and Guidelines
115	Redetermination		A process performed by the County Office of the Division of Family Resources (DFR) caseworkers, to determine whether a currently eligible member continues to be eligible to receive benefits.	MCO Policies and Procedure Manual
116	Referral		A recommendation or approval by a primary medical provider for a patient to receive care from another physician, provider or facility.	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
117	Reinsurance		Insurance purchased by a health plan to protect it against extremely high cost cases. Plans must purchase reinsurance from a commercial re-insurer and establish agreements meeting State requirements.	RFP-4-79, Attachment D, Section 1.5

Item No.	Key Term	Acronym	Definition	Source
118	Remittance Advice	RA	(1) A weekly statement that provides information about a plan's claims processing and financial activity. (2) Claims payment summary statement issued to providers.	Indiana Health Coverage Program Manual Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
119	Resource Based Relative Value System	RBRVS	(1) A methodology for weighing the value of different medical services, often used to develop a fee schedule. (2) A classification system used to determine reimbursement to physicians based on training and skill required to perform a given health care service.	Indiana Health Coverage Program Manual Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
120	Respite Care		Inpatient care for up to five days at a time that is provided to the member only when necessary to provide relief for the member's family or caregivers.	Indiana Health Coverage Programs Hospice Provider Manual
121	Restricted Card Program		Restriction of a member to particular providers, as determined by the State for the purpose of reducing fraud and abuse by the member. A lock-in member is required to obtain an Indiana Health Coverage Program (IHCP) covered services from specifically-designated providers only. Restricted Card Program is also known as "Lock-in".	Indiana Health Coverage of Programs Provider Manual
122	Retroactive Eligibility		Eligibility for Hoosier Healthwise members under benefit Packages A and B that can be established up to three months prior to the member's date of application.	Indiana Health Coverage Program Manual
123	Risk-based Managed Care	RBMC	A fully capitated prepayment system where managed care organizations are at risk to arrange for and administer the provision of a comprehensive set of covered services to Hoosier Healthwise members. Members are linked to a Primary Medical Provider (PMP) who contracts directly with the managed care organization.	RFP-4-79, Attachment E, Section 3.2

Item No.	Key Term	Acronym	Definition	Source
124	Rural Health Clinic	RHC	A cost-based reimbursement system of clinics created under the *Rural Health Clinic Services Act of 1977* to provide better access to services for people in rural, medically underserved areas through the use of mid-level practitioners.	MCO Policies and Procedures Manual
125	Shadow Claims		Reports of individual patient encounters with a plan's healthcare delivery system which contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, billed amounts, and rendering/billing providers. Shadow claims can also be known as encounter data.	RFP-4-79, Attachment D, Section 6.5
126	Southern Region		The State is divided into geographic regions for the purpose of capitation rate calculation. The Southern Region includes the following counties: Bartholomew, Brown, Clark, Clay, Crawford, Daviess, Dearborn, Decatur, Dubois, Floyd, Franklin, Gibson, Greene, Harrison, Jackson, Jennings, Knox, Lawrence, Martin, Monroe, Ohio, Orange, Owen, Perry, Pike, Posey, Ripley, Scott, Spencer, Sullivan, Switzerland, Vanderburgh, Vigo, Warrick, Washington.	MCO Policies and Procedure Manual
127	State Fair Hearing		A process through which members appeal a decision of denial or modification of requested medical services to the Hearing and Appeals Office of the Indiana Family and Social Services Administration (IFSSA).	Indiana Health Coverage Program Manual
128	Subcontractor		A state-approved entity that contracts with the managed care organization, or one of the managed care organization's approved subcontractors, to perform a specific part of the managed care organization's obligations under the provisions of the Contract between the State and the managed care organization.	RFP-4-79, Attachment D, Section 1.6

Item No.	Key Term	Acronym	Definition	Source
129	Temporary Assistance to Needy Families	TANF	A cash assistance program for families (i.e., caretakers and children under 18 years old). Temporary Assistance to Needy Families (TANF) replaces the cash-assistance program, Aid to Families with Dependent Children (AFDC).	MCO Policies and Procedure Manual
130	Third Party Liability	TPL	A client's medical payment resources, other than Medicaid, available for payment of medical claims. These resources generally consist of public and private insurance carriers.	Medicaid Rehabilitation Organization Provider Manual
	Unclean Claim		A claim that requires additional information to meet processing standards or criteria.	Hoosier Healthwise MCO Reporting Manual
	Web Interchange		A web-based resource for checking claims status and verifying eligibility for Hoosier Healthwise members.	Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
	Work Plan		A schedule for project facilitation and completion, that includes target dates for task completion, responsible individuals, and documentation on the status of task when target dates for completion have expired.	MCO Policies and Procedure Manual
	Year		A cycle in the Gregorian calendar of 365 or 366 days divided into 12 months beginning with January 1st and ending with December 31st.	Merriam Webster Online Dictionary copyright 2004, "year" definition 2a, http://www.m-w.com